STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005074	A. BUILDING: _____ B. WING _____	09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEACONESS HOSPITAL INC	600 MARY ST EVANSVILLE, IN 47747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the State investigation of two (2) hospital complaints. Facility: 005074 Complaint: #IN00153471 Substantiated: No deficiencies related to the allegations are cited. #IN00155183 Unsubstantiated: Lack of sufficient evidence. Survey Dates: September 9 and 10, 2014 Surveyor: Trisha Goodwin, RN BSE Public Health Nurse Surveyor Deaconess Hospital is in compliance with 410 IAC 15-1.5-2, Infection control, 15-1.5-5, Medical staff, 15-1.5-8, Physical plant, maintenance, and environmental services and 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules. QA: claughlin 09/23/14	S 000		